

ARKANSAS FORESTRY COMMISSION  
ACCIDENT/INJURY INCIDENT REPORT

AFC Unit \_\_\_\_\_

Date of Injury \_\_\_\_\_

Time of Injury \_\_\_\_\_

Location where injury occurred \_\_\_\_\_

Part of body injured \_\_\_\_\_

Was safety equipment provided/worn? Yes \_\_\_\_\_ No \_\_\_\_\_

Briefly explain how injury occurred \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List witnesses to incident \_\_\_\_\_

Did your supervisor ask you if you wanted to see a doctor? Yes \_\_\_\_\_ No \_\_\_\_\_

Did you decline to see a doctor? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, ask supervisor for set of  
Workers Compensation forms to complete.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervisor Signature

Employee: You may retain a copy of form.

Supervisor: Please retain a copy for your records and forward original to Little Rock Personnel.